EXHIBIT 24

DECLARATION OF STEPHEN DEWHURST, PHD

I, Stephen Dewhurst, PhD, declare as follows:

1. I am the Vice President for Research at University of Rochester ("Rochester" or "University") in Rochester, New York. I have held that position since 2023, after serving as Interim Vice President for Research from 2021 - 2023. I am also Vice Dean for Research at the University's School of Medicine and Dentistry ("SMD"), and since 1990 have been a faculty member in the University of Rochester Medical Center ("Medical Center"), an operating unit of the University.

2. As Vice President for Research, I have personal knowledge of the contents of this declaration, or have knowledge of the matters based on my review of information and records gathered by Rochester personnel, and could testify thereto.

3. The University, as an academic research institution, is our region's largest employer, and seventh-largest employer in New York State, and the University annually invests approximately $137 million in research through the School of Medicine and Dentistry. Many faculty join Rochester's SMD because ours is an academic research and teaching health center, where faculty can practice medicine, perform research, and teach the next generation of medical professionals.

4. The University and Medical Center, together with affiliate and partner hospitals and medical centers across the region, provide medical services to over 3 million people across 27 counties in underserved rural and urban settings—an area with the second highest incidence of cancer in the nation—along with ailments such as Alzheimer's disease and Parkinson's disease, musculoskeletal illnesses and an array of rare and complex diseases such as

neuromuscular diseases, Huntington's disease, cystic fibrosis, Lou Gehrig's disease, autoimmune disorders and more.

5. Rochester receives substantial annual funding from the National Institutes of Health ("NIH"), including approximately $188 million in fiscal year 2023-2024. Such funding has helped spur innovation and discovery over the decades. In fact, for more than 50 years, research conducted at our Wilmot Cancer Institute has led to changes in national oncology standards of care, and paradigm-shifting discoveries, including the science behind the HPV vaccine, which has decreased the incidence of cancers associated with HPV by 40%, saving millions of lives worldwide. In addition:

a. Researchers at the University of Rochester's Center for RNA Biology were the first to describe the process by which faulty messenger RNA (mRNA) molecules are degraded, effectively preventing the production of dysfunctional proteins that cause genetic diseases. This discovery has profound implications for treating genetic disorders, as it offers pathways to modulate this process for therapeutic benefit in settings ranging from Fragile X Syndrome to cancer.

b. Our Wilmot Cancer Institute researchers have described new immunotherapy targets in pancreatic adenocarcinoma as a result of their NIH grant funding, directly leading to first-in-human clinical trials for potential live-saving treatments.

c. Researchers at the University of Rochester developed a cutting edge "tissue-on-a-chip" system funded by NIH grants. This system accelerates the development and regulatory approval of new drugs, allowing testing for efficacy and safety

to be done in micro-culture systems rather than humans at a fraction of the time and cost of conventional methods.

d. Current NIH funded research in our Golisano Childrens' Hospital is leading to new insights into the causes of childhood asthma – which is one of the most common diseases of childhood.

e. Current NIH support for our Intellectual and Developmental Disabilities Research Center (IDDRC) is revealing new information about autism spectrum disorders and rare genetic diseases of childhood, while also informing new treatments and therapeutic interventions.

6. The funding Rochester receives from NIH supports critical and cutting-edge medical research, including research on rare neurologic diseases, autoimmune disease, pulmonary hypertension, pediatric degenerative muscular dystrophy, diabetes, lupus, and autism, all of which promise to benefit millions of Americans. For example, the University's Wilmot Cancer Institute has broad fundamental, translational, and clinical expertise in research on aging and cancer, including recent focus on longevity and mechanisms of cancer development, and has one of the largest and most visible clinical geriatric oncology programs in the USA. URMC has also received substantial NIH funding to support pioneering research focused on understanding the genetic mechanisms and progression of muscular dystrophies, leading to the development of potential RNA-based therapies, now advancing to clinical trials.

7. Indirect costs are essential for supporting this research. The NIH's proposal to cut indirect cost rates to 15% would seriously jeopardize all of the research projects described in paragraphs 5 and 6.

8. Indirect costs include construction and maintenance of laboratory and other research space; maintenance and support for clinical imaging and other scientific research equipment, including several items of NIH-funded equipment valued at over $1 million, which for example actively support research-specific imaging for children and adolescents, as well as DNA-sequencing for cancer research. Indirect costs also support the maintenance and modernization of infrastructure to support laboratories and equipment, including network and compute infrastructure and cybersecurity to protect against malign foreign influence. Wilmot has some of the most advanced cancer research technology in the country and technology is only becoming more complex. Without these resources and equipment, we cannot continue our life-saving research and innovation.

9. Physical space costs are one of the largest components of indirect costs, and the amount and quality of space available to researchers has a direct and obvious impact on the amount of research that can be done at Rochester. NIH indirect costs are critical to the support of:

a. Research into the brain development of children and adolescents, that is critically important to our understanding of ailments such as schizophrenia, childhood neurological diseases, and more. Critical to this are infrastructure resources such as UR CABIN - a 6,000-square-foot state-of-the-art facility for conducting magnetic resonance imaging (MRI) research, which includes an NIH-funded Siemens MAGNETOM Prisma 3T whole-body scanner for human research studies.

b. The University of Rochester's Clinical Research Center, which supports a broad range of NIH funded clinical trials that have led to new therapies for rare

neurologic diseases, autoimmune disease, pulmonary hypertension, pediatric degenerative muscular dystrophy, diabetes, lupus, and autism.

c. High-performance computing resources that enable modeling of RNA structures, and the prediction of novel therapeutic targets, as well as the analysis of complex imaging data from our UR CABIN facility, along with research in a wide array of other areas.

d. Other unique shared resource infrastructure, including Rochester's PEAK lab. PEAK provides resources for integrating human performance measurement, physiology data, biospecimen analysis, and other clinical and biopsychosocial outcomes into clinical and translational cancer control research studies. It provides services such as human performance and physiology assessment, liquid biospecimen processing, and Luminex and ELISA-based biospecimen and biomarker profiling. Space and expertise require funding through indirect cost recovery, and interpretation of human clinical trials for new cancer therapies would be adversely impacted if this lab were closed.

e. Our plans to construct a new cyclotron facility that will address both research initiatives and patient care will be adversely impacted by a major shortfall in NIH indirect costs. This facility would provide a unique resource for imaging of human tumors and other conditions that is not presently available to the 3 million people that our clinical and research enterprise serves.

10. In addition, indirect costs fund the administration of awards, including staff who ensure compliance with a vast number of regulatory mandates from agencies such as NIH.[1] These

[1] https://grants.nih.gov/grants/policy/nihgps/nihgps.pdf

mandates serve many important functions, including protecting human and animal subjects involved in research; ensuring research integrity; satisfying public access requirements for research data; properly managing and disposing of chemical and biological agents used in research; preventing financial conflicts of interest; managing funds responsibly and transparently; administering grants; preventing inappropriate access of intellectual property, technologies, or national security expertise by foreign adversaries; complying with NSPM-33 and similar directives relating to malign foreign activities; and providing the high level of cybersecurity, data storage, and computing environments mandated for regulated data.

11. Recovery of Rochester's indirect costs is based on predetermined rates that have been contractually negotiated with the federal government.

12. Through fiscal year 2023, the predetermined indirect cost rate is 54% across the University, including the University of Rochester Medical Center.

13. The impact of a reduction in the indirect cost rate would be devastating. Of the approximately $188 million in NIH funding that Rochester received in fiscal year 2023-2024, approximately $122 million was allocated for direct costs, and approximately $66 million for indirect costs. Similarly, in fiscal year 2024-2025, Rochester would expect to receive a three percent increase, based on historic trends, in the amount of $193 million in NIH funding, which would also include approximately $66 million for indirect costs, and the University has engaged in planning based on these amounts.

14. If—contrary to what Rochester has negotiated with the federal government—the indirect cost rate is reduced to 15%, that would reduce the University's anticipated annual indirect cost recovery by well in excess of $40 million.

15. This reduction will have deeply damaging effects on Rochester's ability to conduct research from day one due to elimination of funding, including the following likely effects:

a. Slowing, pausing or hampering recruitment for NIH clinical trials.

b. Impairing ongoing efforts to recruit top research faculty, as well as top clinicians. As noted elsewhere, faculty (including clinicians) join the University of Rochester Medical Center because it is a leading Academic Health Center, and because it can provide access to cutting-edge research and clinical trials, as well as leading experts in the field.

c. Inability to properly maintain or operate research laboratories and research equipment.

d. Reduction in workforce development, including training the next generation of medical researchers.

e. Undermining our ability to rapidly and efficiently enroll individuals into clinical trials, and undermining our ability to efficiently and rapidly meet federal regulatory compliance requirements, due to loss of administrative funding.

f. Delaying or eliminating construction of planned research facilities, including those partially funded by the University.

16. Rochester has for decades relied on the payment of indirect costs. And until now, we have been able to rely on the well-established process of fairly and transparently negotiating indirect cost rates with the government to inform our budgeting and planning. Operating budgets rely on an estimate of both direct and indirect sponsored funding to plan for annual staffing needs (*e.g.*, post-docs, PhD students, and other research staff), infrastructure support (*e.g.*, IT networks,

regulatory compliance, and grant management support), and facility and equipment purchases. And in some cases, Rochester has long-term obligations to be satisfied by budgeted grant funding, including associated indirect cost recovery, to fulfill these commitments, such as:

a. Maintaining and paying for long-term service contracts covering major scientific instruments used for imaging for clinical research (e.g., the MRI machines in Rochester's CABIN facility) and other scientific research equipment and infrastructure, such as DNA sequencing equipment that supports human genetic research and studies of the genetic mutations that drive cancer.

b. Maintaining and modernizing physical and digital infrastructures to support laboratory space and equipment.

c. Supporting long-term experiential learning for admitted PhD students representing the future of the U.S. biomedical research workforce.

d. Continuing long-term studies of clinical research cohorts spanning up to 10 years or longer, including support for necessary staff, equipment and infrastructure.

e. Developing and maintaining an information infrastructure that supports current cybersecurity frameworks.

17. In addition to the immediate impacts and reliance interests described above, there are longer term impacts that are both cumulative and cascading.

18. Disruptions to Rochester's research will also have negative effects across Western and Central New York State. As stated above, the University and Medical Center along with affiliates and partners provide critical care to over 3 million individuals across 27 counties, including rural areas with no alternative providers. The Medical Center employs over 3,000

individuals as part of the University's research enterprise. Rochester's research also fuels spending in the regional economy, including by driving discoveries that launch new ventures, attract private investment, and make a positive social and health impact. A massive reduction in Rochester's research budget would immediately and seriously jeopardize these contributions to New York State and would have a negative multiplier effect on the local and regional economy.

19. Nor can Rochester easily cover the funding gap itself, as the University already invests approximately $137 million annually to its research mission through the School of Medicine and Dentistry—an amount that is already imperiled due to pressures associated with reimbursement of clinical care, large increases in staffing costs, changes in the clinical workforce, and other market realities.

20. While Rochester maintains an endowment, it is neither feasible nor sustainable to use endowment funds or other revenue sources to offset shortfalls in indirect cost recovery, for several reasons:

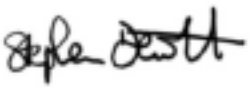
a. A significant portion of Rochester's endowment is restricted to specific donor-designated purposes, such as scholarships, faculty chairs, and academic programs. Rochester is not legally permitted to use those funds to cover research infrastructure costs.

b. As a non-profit institution, Rochester reinvests any minimal revenue into mission-critical activities, leaving little margin to absorb unexpected funding gaps. In other words, unlike for-profit organizations, Rochester does not generate significant surpluses that could be redirected to research without impacting core academic priorities such as educational programs and financial aid support for students.

21. Moreover, absorbing the financial impact of a lower indirect cost rate, even if it were possible, would create long-term budget pressures on Rochester—which would in turn force reductions in key investments supporting Rochester's faculty, students, staff, research, and teaching infrastructure, as well as other critical activities needed to maintain Rochester's academic excellence.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on February 10, 2025, at Rochester, New York



Stephen Dewhurst